State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/ No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/ No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan)

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: /_/ No limitations /X/ With limitations*

3. Other laboratory and x-ray services.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations X With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations X With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

X Provided: ___ No limitations X With limitations*

* Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrist' services.

/X/ Provided: /__/ No limitations /X/ With limitations*

C1. Not provided.

c. Chiropractors' services.

/X/ Provided: /X/ No limitations /__/ With limitations*

/__/ Not provided.

d. Other Practitioner' Services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/__/ Not provided.

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exist in area.

/X/ Provided: /__/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: /__/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: /__/ No limitations /X/ With limitations*

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

8. Private duty nursing services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/XX/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided

b. Dentures.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

d. Eyeglasses

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Preventive services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

d. Rehabilitative services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: /X/ No limitations /_/ With limitations*

/_/ Not provided.

b. Nursing facility services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Services in an Intermediate Care Faility for the Mentally Retarded

15. a. ~~Nursing facility services~~ (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

~~b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.~~

~~☒ Provided: ☐ No limitations ☒ With limitations*~~

~~☐ Not provided.~~

f. 11/1/90

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ **Provided:** ☐ **No limitations** ☒ **With limitations***

☐ **Not provided.**

17. Nurse-midwife services.

☒ **Provided:** ☒ **No limitations** ☐ **With limitations***

☐ **Not provided.**

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ **Provided:** ☐ **No limitations** ☒ **With limitations***

☐ **Not provided.**

***Description provided on attachment.**

1. Inpatient Hospital Services

a. Payment is made for inpatient hospital care as medically necessary. Each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program; this requirement does not apply to emergency admissions. Weekend stays associated with a Friday or Saturday admission will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing

b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.

c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:

(a) Biopsy: breast, cervical node, cervix, lesions (skin subcutaneous, submucous), lymph node (except high axillary excision, etc.), and muscle.
(b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/condylomas, anterior nose bleeds, and cervix.
(c) Circumcision.
(d) Dilation: dilatation and curettage (diagnostic or therapeutic non-obstetrical); dilatation/probing of lacrimal duct.
(e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint
(f) Exam under anesthesia (pelvic).

g) Excision: bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
h) Extraction: foreign body, and teeth (per existing policy).
i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
j) Hymenotomy.
k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
l) Meatotomy/urethral dilation, removal calculus and drainage of bladder without incision.
m) Myringotomy with or without tubes, otoplasty.
n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, otoscopy, and sigmoidoscopy or proctosidmoidoscopy.
o) Removal: IUD, and fingernail or toenails.
p) Tenotomy hand or foot.
q) Vasectomy.
r) Z-plasty for relaxation of scar/contracture.

d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2a. Outpatient Hospital Services

Hospital outpatient services are limited to therapeutic and diagnostic services as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration).

Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification

documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2b. Rural Health Clinic Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-A pertaining to those ambulatory services, except that limitations pertaining to qualifications of provider shall not apply. Reimbursement is not made for the service of physician assistants.

With regard to services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Public Health free to provide immunizations for Medicaid recipients. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any types(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

2c. Federal Qualified Health Center Services

Federal qualified health center (FQHC) services are limited to FQHC services as defined in the Social Security Act, including ambulatory services offered by a FQHC and which are included in the state plan.

3. Other Lab and X-Ray Services

Laboratory Services limited to a benefit schedule of covered laboratory procedures when ordered or prescribed by a duly-licensed physician or dentist.

State Kentucky

paragraph, existed; and such certification must also indicate the procedures used in providing such services. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

X-ray (radiological) services provided pursuant to 42 CFR 440.30 shall be limited to those procedures provided by a facility licensed to provide radiological services and which meets the requirements of 42 CFR 440.30 and other requirements as described herein.

(a) The facility shall participate in the Medicare Program;

(b) The procedure shall be ordered by a licensed physician, oral surgeon or dentist;

(c) The services shall be provided under the direction or supervision of a licensed physician;

(d) The facility shall not be a hospital outpatient department or clinic; and

(e) If the facility provides covered laboratory services, the facility must meet 42 CFR Part [redacted] (CLIA) requirements with regard to the laboratory services. (493 P&I HCFA 1/13/93)

4.a. Nursing Facility Services (Other Than Services in an Institution for Mental Diseases) for Individuals 21 Years of Age or Older

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, X-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

A. Dental Services

(1) Out-of-Hospital Care

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency and shown in provider manual.

Services not listed in the provider manual will be pre-authorized when medically necessary.

(1) Hospital Care

Medicaid reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

B. Hearing Services

Audiological Benefits

(a) Coverage is limited to the following services provided by certified audiologists:

1) Complete hearing evaluation;
2) Hearing aid evaluation;
3) A maximum of three follow-up visits within the six month period immediately following fitting of a hearing aid, such visits to be related to the proper fit and adjustment of that hearing aid; and
4) One follow-up visit six months following fitting of a hearing aid, to assure a patient's successful use of the aid.

(b) Services not listed above will be provided when medically necessary upon appropriate pre-authorization.

(b) Exception to the above limitations may be made through preauthorization if need is indicated in the individual case.

(2) Hearing Aid Benefits

Coverage is provided on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a participating hearing aid dealer.

C. Vision Care Services

(1) Optometrists' services are provided to children under 21 years of age. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses are provided only to children under age 21. Coverage for eyeglasses is limited to two (2) pairs of eyeglasses per year per person.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

4.b EPSDT Services (continued)

D. Discretionary Services under EPSDT. For neonatal care related to any of the following diagnoses, an infant (i.e., child not more than twelve (12) months of age) EPSDT eligible recipient may transfer from a hospital with a level III neonatal unit to a different hospital with a level II or level I neonatal unit with the transfer considered a new admission. A "level III neonatal unit" means a unit able to provide the full range of resources and expertise required for the management of any complication of the newborn; a nurse/patient ratio of 1:2 is required. A "level II neonatal unit" means a unit able to provide care to the moderately ill infant who requires various support services; a nurse/patient ratio of 1:4 is required. A "level I neonatal unit" means a unit providing care to infants with uncomplicated conditions; normal nursery staffing is required.

Neonatal Related Diagnoses

(1) Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy.
(2) Fetus or newborn affected by maternal complications of pregnancy.
(3) Fetus or newborn affected by complications of placenta, cord, and membranes.
(4) Fetus or newborn affected by other complications of labor and delivery.
(5) Slow fetal growth and fetal malnutrition.
(6) Disorders relating to short gestation and unspecified low birthweight.
(7) Disorders relating to long gestation and high birthweight.
(8) Birth Trauma
(9) Intrauterine hypoxia and birth asphyxia.
(10) Respiratory distress syndrome.
(11) Other respiratory conditions of fetus and newborn.
(12) Infections specific to the perinatal period.
(13) Fetal and neonatal hemorrhage.
(14) Hemolytic disease of fetus or newborn, due to isoimmunization.
(15) Other perinatal jaundice.
(16) Endocrine and metabolic disturbances specific to the fetus and newborn.
(17) Hematological disorders of fetus and newborn.
(18) Perinatal disorders of digestive system.
(19) Conditions involving the integument and temperature regulation of fetus and newborn
(20) Congenital anomalies and related surgical procedures.
(21) Other and ill-defined conditions originating in the perinatal period.

4.b. EPSDT Services (continued)

E. The Medicaid program shall provide such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan.

4.c. Family planning services and supplies for individuals of child-bearing age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

5. Physicians' Services

A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

B. Coverage for established patient evaluation and management office or other outpatient services of moderate or high complexity is limited to one (1) per recipient, per physician, per diagnosis, per twelve (12) month period.

C. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.

D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

E. A patient "locked in" to one physician due to over-utilization may receive physician services only from his/her lock-in provider except in the case of an emergency or referral.

F. The cost of preparations used in injections is not considered a covered benefit, except for the following:

(1) The Rhogam injection.
(2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
(3) Depo Provera provided in the physician office setting.
(4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).

G. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.

H. Physician - patient telephone contacts are not covered.

I. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:

(1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.

(2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

J. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed.

K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.

L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.

M. Epidural injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.

6. Medical care and any other type of Remedial Care

a. Podiatry services are provided to both the categorically needy and medically needy in accordance with the following limitations.

(1) Coverage. The Medical Assistance (Medicaid) Program will cover medical and/or surgical services provided to eligible Medicaid recipients by licensed, participating podiatrists when such services fall within the scope of the practice of podiatry except as otherwise provided for herein. The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.

(2) Exclusions from Coverage; Exceptions. The following areas of care are not covered except as specified.

Treatment of flatfoot: services directed toward the care or correction of such a service are not covered.

Treatment of subluxations of the foot: surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot are not covered; this exclusion of coverage does not apply to reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures, or to surgical correction that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

Orthopedic shoes and other supportive devices for the feet are not covered under this program element.

Routine foot care: services characterized as routine foot care are generally not covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. Notwithstanding the preceding, payment may be made for routine foot care such as

cutting or removing corns, calluses or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; the patient's condition must have been the result of severe circulatory embarressment or because of areas of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying systemic conditions contemplated and which would justify coverage; where the patient's condition is one (1) of those designated by an asterisk (*), routine procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy for such a condition, and this doctor's name must appear on the claim form:

- *Diabetes mellitus;
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occulsive peripheral arteriosclerosis);
- Buerger's disease (thromboangitis obliterans);
- Chronic thrombophlebitis;
- Peripheral neuropathies involving the feet:

  1. *Associated with malnutrition and vitamin deficiency, such as: malnutrition (general, pellagra); alcoholism; malabsorption (celiac disease, tropical sprue); and pernicious amenia;
  2. *Associated with carcinoma;
  3. *Associated with diabetes mellitus;
  4. *Associated with drugs and toxins;
  5. *Associated with multiple sclerosis;
  6. *Associated with uremia (chronic renal disease);
  7. Associated with traumatic injury;
  8. Associated with leprosy or neurosyphilis; and
  9. Associated with hereditary disorders, such as: hereditary sensory radicular; neuropathy, angiokeratoma corposis; and diffusum (Fabry's), amyloid neuropathy.

Services ordinarily considered routine are also covered if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections are also covered as they are considered outside the scope of "routine."

(3) Provision relating to Special Diagnostic Tests. Plethysmography is a recognized tool for the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which would have a bearing on the patient's candidacy for foot surgery. The method of plethysmography determines program coverage.

Covered methods include:

- Segmental, including regional, differential, recording oscillometer, and pulse volume recorder;
- Electrical impedance; and
- Ultrasonic measure of blood flow (Doppler).

Noncovered methods include:

- Inductance;
- Capacitance;
- Strain gauge;
- Photoelectric; and
- Mechanical oscillometry.

Venous occulusive pneumoplethysmography would be appropriate only in the setting of a hospital vascular laboratory.

(6) Medical care and Any Other Type of Remedial Care

(b) Optometrists' services are provided to both the categorically needy and the medically needy. Such coverage includes writing of prescriptions, diagnosis, and provision of treatment to the extent such services are within the lawful scope of practice (licensed authority) of optometrists licensed in the state of Kentucky. The following limitations are also applicable:

1) Provision of eyeglasses is limited to recipients under age twenty-one (21).
2) Contact lenses are not covered.
3) Telephone contacts are not covered.
4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
5) If medically necessary, prisms shall be added within the cost of the lenses.

(c) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Registered Nurse Practitioner (ARNP) Services

(1) An ARNP covered service shall be a medically necessary service provided within the legal scope of practice of the ARNP and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.

(2) ARNP's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.

(3) An ARNP desiring to participate in the Medical Assistance Program shall:

(a) Meet all applicable requirements of state laws and conditions for practice as a licensed ARNP;
(b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
(c) Accompany each participation application with a current copy of the ARNP's license; and
(d) Provide and bill for the services in accordance with the terms and conditions of the provider participation agreement.

(4) Administration of anesthesia by an ARNP is a covered service.

(5) The cost of the following injectables administered by an ARNP in a physician or other independent practitioner's office shall be covered:
a. Rho (D) immune globulin injection;
b. Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
c. Depo-Provera contraceptive injection;
d. Penicillin G and ceftriaxone injectable antibiotics; and
e. Epidural injections administered for pain control.

(6) An outpatient laboratory procedure by an ARNP who has been certified in accordance with 42 CFR, Part 493 shall be covered.

Other Licensed Practitioners' Services (continued)

(d) Ophthalmic dispensers' services, limited to dispensing service or a repair service (for eyeglasses provided to eligible recipients), are covered. The following limitations are also applicable:

(1) Telephone contacts are not covered;

(2) Contact lens are not covered;

(3) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, physician assistant or advanced registered nurse practitioner, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place of residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost-effectiveness when compared with other care options.

7a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7b. Homehealth Aide Services

Homehealth aide services must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

7c. Medical Supplies, Equipment, Prosthetics, and Orthotics Suitable for Use in the Home

Each Provider desiring to participate as a durable medical equipment, prosthetic, orthotic, or medical supply provider must be a participating Medicare provider and sign a provider agreement with the Department for Medicaid Services.

Durable medical equipment, prosthetics, orthotics, and medical supplies are covered only in accordance with the following conditions:

1. The Department covers items specified in the Medicare region C DMERC DMEPOS Suppliers Manual. The provider may, however, submit requests for other specific items not covered by Medicare or not routinely covered by the Medicaid Program for consideration.

The provider submits a certificate of medical necessity (CMN) and, if required, a prior authorization form and any other documentation to support medical necessity. Unless specifically exempted by the Department, DME items, supplies, prosthetics, and orthotics will require a CMN completed by the prescriber that will be used by the department to document medical necessity.

2. Coverage of durable medical equipment and supplies, prosthetics, and orthotics for use of patients in the home is based on medical necessity and the requirements of 42 CFR 440.230(c).

   Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.

3. Any equipment, prosthetic, orthotic, or supply billed (either purchased or repaired) at $300 or more must be prior authorized by the Department.

4. The criteria used in the determination of medical necessity includes an assessment of whether the item is:
   a. Provided in accordance with 42 CFR 440.230;
   b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition;
   c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
   d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider;
   e. Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
   f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and,

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR 441 Subpart B, for recipients under twenty-one (21) years of age.

5. An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to stand repeated use. Coverage of an item of durable medical equipment, prosthetic, orthotic, or medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary, and reasonable.

6. The following general types of durable medical equipment, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:

a. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
b. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
c. Physical fitness equipment, such as exercycles and treadmills; and,
d. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators.

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, or speech pathology services provided by a home health agency must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Audiology services are not provided under this component. Physical therapy, occupational therapy, or speech pathology services provided by a medical rehabilitation facility are not provided under this component.

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.
2. Family planning clinics.
3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.
4. Out-patient surgical clinics.
5. Other clinics authorized under 42 CFR 440.90.

5a. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of the physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

5b. Specialized Children's Services Clinics

Specialized Children's Services Clinics provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under the age of 18. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates and/or provides needed services. Sexual abuse examinations are available to children from 18 to 20 years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination and mental health screening) through the physician and mental health components of the state plan.

Medicaid coverage of services provided by clinics is limited to a sexual abuse medical exam which includes the following components:

1. A physical exam provided by a licensed physician who has received specialized training in providing medical exams of sexually abused children and the use of a colposcope; and

2. A mental health screening provided by a mental health professional under the direct supervision of a physician. Mental health professionals shall include, but not be limited to the following: social workers, psychologists, art therapists, ARNPs and other qualified therapists who are required to have specialized training in the screening and assessment of sexually abused children. Under direct supervision means the physician shall assume professional responsibility for the service provided by the mental health professional.

Providers of clinic services are employed by, under contract, or have a signed affiliation agreement with the clinic.

Reimbursement methodology is described in Attachment 4.19-B, Section XXXII.

13. Dental Services

A. A listing of dental services available to recipients age 21 and over is maintained at the central office of the single state agency and is shown in the provider manual.

Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

B. Out-of Hospital Dental Services

A listing of dental services available to Medicaid recipient is maintained at the central office of the single state agency and is shown in the provider manual.

C. In-Hospital Care

Reimbursement shall be made for a medically necessary dental service provided by a dentist in an inpatient or outpatient hospital setting if:

(a) The Medicaid recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if the dental service was provided in the dentist's office; and

(b) In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in the inpatient or outpatient hospital setting due to the recipient's physical, mental or behavioral condition.

D. Oral Surgery

A listing of oral surgeon services available to Medicaid recipients is maintained at the central office of the single state agency and is shown in the provider manual.

11. Physical Therapy and Related Services

A. Physical Therapy (Limitations apply to both categories)

Coverage is limited to the provision of such services when (1) provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities as part of an approved plan of treatment or (2) when provided through participating home health agencies or hospital outpatient departments.

B. Occupational Therapy (Limitations apply to both categories)

Coverage is limited to the provision of such services through a participating home health agency, or when provided to patients in Skilled Nursing or Intermediate Care Facilities as part of an approved plan of treatment.

C. Services for Individuals with Speech, Hearing and Language Disorders-Provided by or under supervision of a speech pathologist or audiologi (Limitations apply to both categories.)

(1) Speech Disorders

Coverage is limited to the provision of such services when (1) provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities or (2) when provided through participating home health agencies or in hospital outpatient departments.

12. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses

a. Prescribed Drugs

(1) Coverage is provided for drugs included in the Medicaid Drug List that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs that are on the Preferred Drug List are specified in the Medicaid Drug List. Drugs added to the Preferred Drug list are based on recommendations submitted by the Pharmacy and Therapeutics Advisory Committee to the Secretary of the Cabinet for Health and Family Services for approval. Drugs not on the Preferred Drug List are subject to the prior authorization process as listed below. Drugs that require prior authorization are specified in the Medicaid Drug List. Approval of prior authorization is based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature.

(2) Kentucky will provide reimbursement for covered outpatient drugs when prescribed by an enrolled licensed provider within the scope of their license and practice as allowed by State law and in accordance with Section 1927 of the Social Security Act. This will apply to drugs of any manufacturer that has entered into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. The State has established a preferred drug list with prior authorization for drugs not included on the preferred drug list. The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72-hour supply of drugs in emergency circumstances. The preferred drug list meets the formulary requirements that are specified in Section 1927(d)(4) of the Social Security Act.

(3) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Medicaid Drug List or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:

(a) A drug for which the FDA has issued a "less than effective (LTE)" rating or a drug "identical, related, or similar" to an LTE drug;
(b) A drug that has reached the termination date established by the drug manufacturer;

(c) A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement in accordance with 42 USC 1396r-8(a) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payment for the non-rebated drug. Note: Because federal financial participation is not generally available for a non-rebated drug, state funds will be used to cover such drugs if necessary to protect the health of a Medicaid recipient and no other appropriate options exist;

(d) A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program;

(e) A drug used to treat sexual or erectile dysfunction, unless the drug is FDA approved to treat a condition other than sexual or erectile dysfunction. (This provision is effective 01-01-06); and

(f) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service. However, a legend drug may be provided through prior authorization to a recipient admitted to an inpatient facility that does not bill patients, Medicaid, or other third-party payers for health care services.

(4) A patient "locked-in" to one pharmacy due to over-utilization may receive pharmacy services only from his/her lock-in provider except in the case of an emergency or by referral.

(5) If authorized by the prescriber, a prescription for a controlled substance in Schedule III-V may be refilled up to five times within a six month period from the date the prescription was written or ordered; a noncontrolled substance may be refilled up to 11 times within a 12 month period from the date the prescription was written or ordered. In addition, a prescription fill for a maintenance drug shall be dispensed in a 92-day supply if a recipient has demonstrated stability on the maintenance drug. However, a 92-day supply of a maintenance drug shall not be dispensed if a prescribing provider specifies that the quantity should be less. Also, individuals receiving supports for community living services shall not be subject to the 92-day supply requirement.

(6) Kentucky will cover an unlimited number of generic drug prescriptions and up to three brand name prescription drugs per recipient per month. However, if a physician provides sufficient information that a medical need exists for a Medicaid member to receive more than three brand name drug prescriptions in a one-month period, an exception to the three brand allowance will be allowed.

(7) A refill of a prescription shall not be covered unless at least 80 percent of the prescription time period has elapsed. However, a refill may be covered before 80 percent of the prescription time period has elapsed if the prescribing provider submits a prior authorization request for override consideration.

(8) Supplemental Rebate Program:
The state is in compliance with Section 1927 of the Social Security Act. The state has the following policies for the Supplemental Rebate Program for the Medicaid population:

(a) CMS has authorized the State of Kentucky to enter into the Michigan multi-state pooling agreement (MMSPA) retroactive to the quarter State Plan Amendment 04-006 was filed. The Amendment to Supplemental Drug Rebate Agreement was submitted to CMS on January 6, 2005.

. Other diagnostic, screening, preventive and rehabilitative services, ie. other than those provided elsewhere in this plan.

a, b, c, and d. Such services are covered only when provided by mental health centers, primary care centers, and other qualified providers, licensed in accordance with applicable state laws and regulations. Reimbursement for services under this authority will not be made when delivered in a long-term care environment as such services are reimbursable as a routine cost to the institution.

14.b. and c. Nursing Facility Services for Individuals Age 65 or Older in Institutions for Mental Diseases.

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

Services in an Intermediate Care Facility for the Mentally Retarde

15.a. ~~Nursing Facility Services~~ (Other Than Such Services In an Institution for Mental Diseases) for Persons Determined, in Accordance with Section 1902(a)(31)(A) of The Act, to be in Need of Such Care

Program benefits are limited to eligible recipients who require intermittent nursing facility care, continuous personal care and/or supervision. These services must be preauthorized and must be reevaluated every six months. If the reevaluation of care reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

~~b.~~ Including Such Services in a Public Institution (Or Distinct Part Thereof) For the Mentally Retarded or Persons with Related Conditions.

Program benefits are limited to those recipients who require intermittent nursing facility care, continuous personal care and/or supervision and/or who require care which is being provided in accordance with an established plan developed as a result of a comprehensive medical, social, and psychological evaluation. These services must be preauthorized and must be reevaluated every six months thereafter. If the reevaluation of care reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program for 15.a. and 15.b. above when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges: the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, X-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

The following limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

(1) Program benefits are limited to eligible recipients who require inpatient psychiatric facility services on a continuous basis as a result of a severe mental or psychiatric illness (including severe emotional disturbances) as shown in ICD-9-CM~~ (except as further excluded in item 3, below)~~. Services shall not be covered if appropriate alternative services are available in the community. Services must be preauthorized and reevaluated at thirty day intervals. 9.11.91 (P.I.-HCFA)

(2) Services may be provided in a psychiatric hospital; or in a licensed psychiatric residential treatment facility which meets the requirements of 42 CFR 441 Subpart D.

20.b. Rehabilitative Services for Pregnant Woman

The following substance abuse services are covered for pregnant and postpartum women for a sixty-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls for treatment of a substance related disorder, excluding nicotine dependence.

(1) Substance abuse assessment. An assessment is to include the presenting problem, substance abuse diagnosis (if identified) and the development of an initial plan of care.

(2) Prevention Services. The prevention services are designed to reduce the risk that an individual will initiate or continue using alcohol, tobacco, and other drugs during pregnancy and the postpartum period. Services will be delivered through approved protocols that may include pre-test and post test surveys, videos with discussion guides, motivational interviewing, participant workbooks, and supportive therapeutic interventions. Services are provided with a face-to-face contact between an individual and a qualified provider, on an outpatient basis and may be delivered in an individual or group setting. Individuals are provided the following services based upon their needs:

(a) Universal prevention service.

1. Targeted audience: Includes members of the population that exhibits no characteristics or behaviors that place them at greater risk of developing alcohol or drug problems or substance dependence.
2. Goals and objectives:
   a. Continued or increased perceptions of potential harm to the fetus as a result of using alcohol, tobacco or other drugs during pregnancy;
   b. Continued or increased intentions to not use alcohol, tobacco and other drugs during pregnancy and lactation; and
   c. Increased ability to recognize signs of postpartum depression and risk for substance abuse following pregnancy.
3. Service limitation: A substance abuse universal prevention service shall be provided in ¼ hour increments, not to exceed a total of two (2) hours.

(b) Selective prevention service.

1. Targeted audience: Includes members of the population that have been identified as having a greater incidence of problems associated with their use and/or higher incidences of developing chemical dependence (i.e. Children of Alcoholics, survivors of sexual abuse or domestic violence).
2. Goals and objectives:
   a. Abstinence from alcohol, tobacco and other drugs during pregnancy and lactation;
   b. Increased commitment to not use during pregnancy and lactation;
   c. Continued or increased perceptions of potential harm to a fetus when alcohol, tobacco or other drugs are used;
   d. Increased awareness of personal vulnerability to alcohol or drug dependency or other problems throughout life;
   e. Attitude changes which support an individual in making low risk choices related to tobacco, alcohol and other drug use during and following pregnancy; and
   f. Developing skills necessary to make and maintain low risk alcohol and other drug choices throughout life.
3. Service limitation. A selective prevention service shall be provided in ¼ hour increments, not to exceed a total of nineteen (19) hours.

20.b. Rehabilitative Services for Pregnant Woman (continued)

(c) Indicated prevention service.

1. Targeted audience: Includes members of the population that do not have a diagnosis of substance abuse or dependency, but do report actually experiencing some problems related to their use of alcohol and drugs.
2. Goals and objectives:
   a. Decreased alcohol and other drug use;
   b. Attitude changes which support an individual in making low risk choices related to alcohol and other drug use;
   c. A greater readiness for and response to treatment for an individual with a substance abuse related diagnosis who is receiving this service as an adjunct to a substance abuse treatment plan; and
   d. Increased skills necessary to make and maintain low risk alcohol and other drug use choices during pregnancy and throughout life.
3. Service limitation. An indicated prevention service shall be provided in ¼ hour increments, not to exceed a total of twenty-seven (27) hours.

(d) Qualifications of providers. All of the prevention services are provided by a Kentucky certified preventionist or a Qualified Substance Abuse Treatment Professional (QSATP) with training in prevention strategies and procedures.

(3) Outpatient services.

(a) Outpatient services may include:

1. Individual therapy;
2. Group therapy;
3. Family therapy. This service is counseling provided to an eligible individual and one (1) or more significant others with the primary purpose of which is the treatment of the individual's condition;
4. Psychiatric evaluation provided by a psychiatrist;
5. Psychological testing provided by a psychologist;
6. Medication management provided by a physician or an advanced registered nurse practitioner; and
7. Collateral care. Involves counseling or consultation services provided directly or indirectly to the recipient through the involvement of a person or person's in a position of custodial control or supervision of the individual in the counseling process. Services are to meet the treatment needs of the eligible individual and shall be a part of the individual's treatment plan. Presence of the recipient in the counseling session is not necessarily required. However, when the recipient is present, reimbursement for the collateral counseling and individual or group counseling for the same session is not allowed.

(b) Service limitations.

1. Group therapy.
   a. There shall be no more than twelve (12) persons in a group therapy session; and
   b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse and other self-help groups.
2. Collateral care shall be limited to individuals under age twenty-one (21) and no more than four and one-half (4.5) hours of service shall be reimbursed during a one (1) month period.
3. No more than eight (8) hours of outpatient services shall be reimbursed during a one (1) week period.

20.b. Rehabilitative Services for Pregnant Woman (continued)

(4) Day Rehabilitation Services.

(a) Shall be an array of substance abuse treatment services in a structured program format that is scheduled to take place multiple hours a day, several times a week and may include individual and group therapy, information on substance abuse and its effects on health, fetal development and interpersonal relationships.

(b) May be covered when provided to an individual in a non-residential setting or as a component of a residential program.

(c) Service limitations:

1. Reimbursement for a day rehabilitation service provided in a non-residential setting shall be limited to no more than 7 hours per day not to exceed twenty (20) hours per week.
2. Reimbursement for a day rehabilitation service provided in a residential setting shall be limited to no more than 8 hours per day not to exceed forty-five (45) hours per week.
3. Payment shall not be made for care or services for any individual who is a patient in an institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.
4. Room and board costs shall not be covered under this benefit.

(5) Outpatient and Day Rehabilitation services shall be provided by a qualified substance abuse treatment professional (QSATP) that meets one of the following requirements:

(a) A certified alcohol and drug counselor; or

(b) An individual who holds a license or certification in medicine, psychology, social work, nursing, marriage and family therapy, professional counselor, or art therapy with 24 hours of additional training in substance abuse or dependency related problems and information specific to working with the target population; or

(c) A bachelor's or greater degree with additional training of 45 hours with 12 hours in substance abuse or dependence related problems, 12 hours specific to the target population, 12 hours in prevention strategies and procedures, and the remaining 9 hours may be in one or more of the identified training topics.

(6) Community support services.

(a) A community support service shall be provided if the service is identified as a need in the individual's treatment plan.

(b) A community support service shall be a face-to-face or telephone contact between an individual and a qualified community support provider.

(c) A community support service shall include:

1. Assisting an individual in remaining engaged with substance abuse treatment or community self-help groups;
2. Assisting an individual in resolving a crisis in an individual's natural environment; and

20.b. Rehabilitative Services for Pregnant Woman (continued)

3. Coaching an individual in her natural environment to:
   a. Access services arranged by a case manager; and
   b. Apply substance abuse treatment gains, parent training and independent living skills to an individual's personal living situation.

(d) A community support provider shall coordinate the provision of community support services with an individual's primary provider of case management services.

(e) Community support staff qualifications.

1. A high school diploma or general equivalent diploma.
2. Two years of supervised experience in substance abuse treatment setting and knowledge of substance abuse related self-help groups.
3. Twenty hours of training on the dynamics and treatment of substance abuse, recovery issues unique to pregnant women and women with dependent children and HIV positive individuals, strategies to defuse resistance, professional boundary issues that address enabling behaviors and protecting a staff member, who may be a recovering substance abuser, from losing their own sobriety.

(7) Reimbursement for a substance abuse service shall not be payable for an individual who is a resident in a Medicaid-reimbursed inpatient facility.

(a) Reimbursement for services shall be based on the following units of service:

1. Universal prevention service shall be a one-quarter (1/4) hour unit;
2. Selective prevention service shall be a one-quarter (1/4) hour unit;
3. Indicated prevention service shall be a one-quarter (1/4) hour unit;
4. Outpatient service shall be a one-quarter (1/4) hour unit for the following modalities:
   a. Individual therapy;
   b. Group therapy;
   c. Family therapy;
   d. Psychiatric evaluation;
   e. Psychological testing;
   f. Medication management; and
   g. Collateral care.
5. An assessment service shall be a one-quarter (1/4) hour outpatient unit;
6. Day rehabilitation services shall be a one (1) hour unit;
7. Case management services shall be a one-quarter (1/4) hour unit; and
8. Community support shall be a one-quarter (1/4) hour unit.

(b) Qualifications of Providers

1. Services are covered only when provided by any mental health center, their subcontractors and any other qualified providers, licensed in accordance with applicable state laws and regulations.
2. The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
3. A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.

State Kentucky

18. Hospice Limitation

The following hospice limitation is applicable: A Medicaid eligible individual who wishes to elect coverage under Medicaid for hospice care and who is eligible for hospice care under Medicare, must elect coverage under both programs for coverage to exist under Medicaid.

24. Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary.

A. Transportation

1. Definitions.

a. Ambulance transportation includes air and ground transportation provided at advanced life support level or basic life support levels by an appropriately licensed carrier.

b. Medical service area is made up of the recipient's county of residence or a contiguous county.

2. Ambulance Services.

a. An emergency ambulance service shall be provided without prior authorization to and from the nearest hospital emergency room. If a hospital emergency room is not available, a statement from an attending physician associated with the facility from which the patient receives services verifying medical necessity of stretcher ambulance services and the nature of the emergency services provided to the patient shall be required.

b. A non-emergency ambulance service to a hospital, clinic, physician's office or other medical facility for provision of a Medicaid covered service, exclusive of a pharmacy service, shall be covered upon referral from a licensed medical professional for a recipient whose medical condition warrants transport by stretcher.

c. When it is determined by the attending physician that ground ambulance is not appropriate, a referral may be made for air ambulance transport to a medical facility beyond the recipient's county of residence or state boundaries. Medically necessary air travel will be covered within the parameters of the allowed reimbursement amounts specified in Attachment 4.19-B, page 20.11. Special authorization by the Commissioner or his designated representative is required for air transportation provided at a cost in excess of these amounts.

d. Ground ambulance transport for in-state non-emergency ambulance travel outside the medical service area shall be covered if prescribed by the attending physician.

e. Ground ambulance transport for out-of-state non-emergency ambulance transport shall only be covered if prior approval is obtained from the Department.

f. Only the least expensive available transportation suitable for the recipient's needs shall be approved.

3. Specially Authorized Non-emergency Medical Transportation

a. A specially authorized transportation service is non-emergency transportation necessary under extraordinary circumstances in which the recipient is required to travel out-of-state for medical treatment unavailable in-state.

b. The Department assures provision of necessary transportation to and from a provider if the recipient has no other transportation resources.

c. If transportation is not available free of charge, the Department will cover the least expensive means of appropriate transportation.

d. Prior approval is required for all specially authorized transportation. When the recipient's medical needs cannot be met within the state, the Department will only approve travel to the nearest facility where those needs can be met.

e. The Department will cover the following specially authorized transportation services:

(1) Transportation for a recipient;

(2) Lodging for a recipient, and a parent or attendant, if necessary;

(3) Meals, when necessary for the recipient to remain away from home and outside a medical facility while receiving treatment;

(4) Transportation and meals for one parent or guardian to accompany a dependent child receiving covered medical services, when treatment requires the child to remain away from home; and

(5) Transportation and meals for an attendant who accompanies a recipient receiving medical services, when there is a justifiable need for an attendant. The attendant can be a parent.

23.d. Nursing Facility Services for Patients Under 21 Years of Age

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.

2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.

3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

(1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).

(2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, respiratory therapy, and ventilator therapy.

23.e. Emergency Hospital Services

Coverage is limited to the provision of emergency services provided in hospitals which have been determined to meet Title XVIII's definition of an emergency hospital.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

/X/ Provided: /X/ With limitations

/ / Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

/X/ Provided: + / / Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

/X/ Provided: + /X/ Additional coverage ++

/ / Not provided.

c. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy to individuals covered under section 1902(a)(10)(A)(ii)(IX) of the Act.

/X/ Provided: + /X/ Additional coverage ++

/ / Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

/X/ Provided: /X/ No limitations /_/ With limitations*

/_/ Not provided.

22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through (C) of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

23. Certified pediatric or family nurse practitioners' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

See item 6d for limitations.

* Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

c. Reserved

d. Nursing facilities for patients under 21 years of age.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

e. Emergency hospital services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

* Description provided on attachment

State: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided __X__ not provided

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

_X_ provided

___ not provided

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

---

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

_X_ Provided ___No limitations _X_ With Limitations* ___Not Provided

*Description provided on attachment.

State/Territory Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERIVCES PROVIDED TO THE MEDICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; and shall be medically necessary and reasonable.

a. A provider must be Medicare and Medicaid certified. Items must be medically necessary.and, if required, prior authorized.

b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.

c. Any item designated by a covered HCPCS codes being reimbursed at $150.00 or more will require prior authorization.

d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.

e. The following general types of durable medical equipment, medical supply, prosthetics or othotics are excluded from coverage under the durable medical equipment program:

1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
3. Physical fitness equipment, such as exercycles and treadmills;
4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
6. Items considered educational or recreational.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	1.	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.
	—	**The following excluded drugs are covered:**
	☐	(a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
	☐	(b) agents when used to promote fertility (see specific drug categories below)
	☐	(c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
	☐	(d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)
	☐	(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)
	☒	(f) nonprescription drugs (see specific drug categories below)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	☐	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
	☒	(h) barbiturates
	☒	(i) benzodiazepines
		(The Medicaid agency lists specific category of drugs below)
		Kentucky Medicaid will cover all nonprescription drug categories for full benefit dual eligible beneficiaries, which is consistent with Kentucky's policy of covering all nonprescription drug categories for non-dual recipients. Herbal products are not covered.

__ **No excluded drugs are covered.**